**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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| Requestor Name and Address:<br>TWELVE OAKS MEDICAL CENTER<br>HOLLAWAY & GUMBERT<br>3701 KIRBY DRIVE SUITE 1288<br>HOUSTON TX 77098 | MFDR Tracking #: M4-05-5713-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>ZURICH AMERICAN INSURANCE CO<br>Box #: 19 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "To date, a total of $4,828.78 has been paid in connection with this claim. It is our position that reimbursement was improperly determined. Rule 134.401(a)(4) of the Texas Workers' Compensation Commission (TWCC), entitled *Acute Care Inpatient Hospital Fee Guideline*, states '[a]mbulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement.' According to the enclosed EOB, the carrier 'PAID PER OPERATIVE RECORD AT MEDICARE GROUP 5 23410 GROUP 3X3 29806 29807 AND 29826 AND GROUP 1 37202 PLUS 25%,…' The carrier's reimbursement of our client's charges at what appears to be the reimbursement scheme for **professional medical services** as based on Medicare group rates plus 25%, is wholly inappropriate criteria for pricing of outpatient hospital surgical claims. Furthermore, the carrier's reimbursement is neither fair nor reasonable on the basis that fee guidelines promulgated by the Texas Workers' Compensation Commission cannot be based solely on the Medicare fee schedule pursuant to Section 413.011 of the Texas Labor Code." "The hospital contends the charges for its services are fair and reasonable…The hospital's rates for the goods and services it provides are similar to and competitive with the general hospitals in the greater Houston, Texas area."

**Amount in Dispute:** $31,240.04

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This was an outpatient admission for the repair of a rotator cuff. Requestor billed a total of $36,068.82! For an inpatient admission, these same services would be reimbursed at $1,118." "The billing is inflated and unreasonable. Zurich American Insurance Company (Zurich) repriced the bill according to Medicare protocol multiplied by a factor of 125%. Implants were not reimbursed inasmuch as they were not documented. They were billed in the amount of $6,210. Upon receiving documentation of the cost of the implants, Zurich will reimburse the Hospital's costs."

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 3/27/2004 through 3/28/2004 | M, N, O, S | Outpatient Surgery | $31,240.04 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 24, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1,

2003, the Division notified the requestor on April 5, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - M-No MAR.
   - N-Not Documented.
   - O-Denial after reconsideration.
   - S-Supplemental payment.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
5. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "The hospital contends the charges for its services are fair and reasonable…The hospital's rates for the goods and services it provides are similar to and competitive with the general hospitals in the greater Houston, Texas area."
   - The requestor did not submit documentation to support that the hospital's rates are "…similar to and competitive with the general hospitals in the greater Houston, Texas area."
   - The requestor does not discuss or explain how additional payment of $31,240.04 would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
   - The Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models… are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs… Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence.

After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION:**

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| | | **11/12/2010** |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
| | | **11/12/2010** |
| Authorized Signature | Health Care Business Management Director | Date |

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**